

THE VIABILITY OF A NATIONAL
HEALTHCARE SYSTEM FOR SOUTH AFRICA:

A KWAZULU-NATAL CASE STUDY

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ABSTRACT

This research is an endeavour to highlight the state of healthcare in South Africa as seen through the eyes of professional health care workers who are at the cold face of healthcare.

Having worked in an environment of inequities and unjust circumstances, healthcare workers expressed their attitudes and beliefs that healthcare are in need of radical change.

There appears to be insight from these professionals that the private and public healthcare sectors should forge a relationship, ultimately benefiting South African society.

More research needs to be done on a major scale to determine more deeply the attitudes and beliefs of healthcare professionals. Such an endeavour will provide a stimulus for policymakers to harness this energy and direct it in a meaningful way in the transformation of healthcare in South Africa.

Chapter 1 focused on several relevant perspectives and definitions on healthcare in South Africa and other countries.

In Chapter 2, attention was given to socio-economic rights as per the South African Constitution and the states obligations to fulfil these rights. These rights were examined in the context of landmark Constitutional Court cases, viz.

Soobramoney versus the State;

TAC versus the State;

and Grootboom versus the State.

These cases give one the essence of interpreting rights and the constitutional obligation of the state to deliver on them.

Healthcare developments in South Africa and other countries together with the RDP and GEAR considerations are outlined in Chapter 3.

Research Methodology is outlined in Chapter 4, emphasizing also the limitations of this study.

Chapter 5 examines the responses to the questionnaires and analyses its findings.

Chapter 6 provides the conclusions and recommendations as well as a critique of healthcare in South Africa.

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ABBREVIATIONS:

ANC	-	African National Congress
COSATU	-	Congress of South African Trade Unions
RDP	-	Reconstruction and Development Programme
GEAR	-	Growth, Employment and Redistribution Programme
NALEDI	-	The National Labour and Economic Development Institute
PHC	-	Primary Health Care
NGO	-	Non-governmental Organisation
DHS	-	District Health System
CAPD	-	Continued Ambulatory Peritoneal Dialysis
MDB	-	Municipal Demarcation Board
BHF	-	Board of Healthcare Funders
IFP	-	Inkatha Freedom Party
MP	-	Member of Parliament
GDP	-	Gross Domestic Product

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**APPENDICES 1, 2, 3 AND CASE REFERENCES
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CHAPTER 1:

INTRODUCTION:

Some 600 hundred people die in South Africa every day from HIV and Aids.

Healthcare around the world in the developed and underdeveloped countries has been pivotal to their successes or failures, countries have used it to further their political cause, fuel their economies through production of drugs and other medical technologies. Some countries hold the monopolies on these productions and sell to potential users in the developing and underdeveloped countries.

South Africa has been embroiled in attacks on its constitutional obligations to provide adequate healthcare and it seems that there will be no end until some form of equity is reached in providing access to comprehensive healthcare to all. South Africa spends R34.4 billion on 35 million people in the public healthcare sector and by comparison spends R40 billion on just seven million people in the private healthcare sector. The World Health Organisation rates South Africa Number 175 out of 197 countries in terms of healthcare services (Basset 2002).

Much has been done by the South African government to promote healthcare. However, much more needs to be done to hold true to its constitutional obligations. Healthcare professionals in South Africa, it will be shown, express

their attitudes and beliefs for a positive move towards a National healthcare system. Despite the government's constant statements that the move towards NHS is being hampered by lack of finances, lack of personnel, lack of infrastructure, many things appear to contradict this, e.g. infrastructure was set up at great cost, why is it not possible to do the same for the much needed healthcare services in the rural areas?

There is a dearth of information and analysts and countless consultants have been commissioned to find suitable models for a healthcare model for South Africa, why is the adoption of the process taking so long when people require and desperately need access to healthcare?

Infrastructure was not a major issue when South Africans went to the polls at the last and previous elections, all this was provided at huge expense, personnel was trained, the IEC-Independent Election Commission, a statutory body, was established for this purpose. Questions obviously arise such as what are the priorities?? IS HEALTHCARE ONE OF THEM, AS IT SHOULD BE?

How important is it as compared with transport, defence, education and social welfare? We can pontificate and analyse and paralyse ourselves with data about healthcare statistics, but the facts are before us all that South Africa desperately needs a solid healthcare infrastructure.

Our nation has a long and very sad history of inequities and the majority of our people are still suffering from ill health. The time has come for government to dislocate these inequities, and present the entire nation with a National Healthcare System consistent with it's obligations in the Constitution of South Africa.

The intention as well as the aims and objectives of this research is to highlight the attitudes and beliefs of healthcare professionals towards establishing a National Healthcare System for South Africans. This research, it is hoped will add value to readers, researchers, academics, policy makers, health managers and students, so as to critically evaluate the current position of healthcare in South Africa.

It must be mentioned that much research has been done on healthcare since 1994 by government, non-governmental organizations and research organizations who have come to analyse and make proposals to government about models of healthcare. The HIV/AIDS devastation has become not only a human bomb, but also a terrain of differences, where billions of USA dollars are spent on research and treatment at all levels.

However, to my knowledge, insufficient work has been done on to ascertain what the citizenry believes and feels should be done to improve healthcare in South Africa. Emanating from this research, it is also hoped that one can

gauge the extent to which the people of South Africa are informed about their constitutional rights. Important test cases will form part of a discussion on the overview and legislative aspects of healthcare in South Africa.

Funding and resourcing a National Healthcare System make up an integral part of this research and responses to the questionnaire will show that there is a misconception that in a developing country, such as South Africa, a National Healthcare System cannot be established.

The Questionnaire has been designed to be interactive so as to extract broad views about healthcare and it is hoped that educationally this exercise was of mutual benefit to both the researcher and the respondents.

The viability of a National Healthcare System for South Africa begins as a hypothesis, it encompasses 3 fundamental aspects, namely,

*that healthcare professionals believe that National Healthcare System be established in South Africa;

*that the government recognises the already well established private healthcare system and accepts it as a willing partner in the establishment of a National Healthcare System;

*that in order for a National Healthcare System to be established speedily, regulatory legislation needs to be introduced to produce a clearer picture of healthcare in South Africa.

Without stifling the private healthcare sector, the nation has mandated government to introduce a system to encourage the co-existence of the private healthcare sector and the public healthcare sector for the benefit and the well being of the nation.

Martin Luther King said **“Of all the forms of inequality, injustice in healthcare is the most shocking and inhumane”** – Martin Luther King, Jr. (Bureau of Labour Education University of Maine 2001-The U.S. Health Care System: Best in the World, or Just the Most Expensive?)

He was absolutely correct.

PERSPECTIVES AND DEFINITIONS:

In its Constitution the World Health Organisation (WHO) defines health as follows,

“Health is a state of complete physical, mental and social well-being and not merely the absence of disease”. (Nadesan, S, Public Health law in South Africa 2000 [2]).

The Department of Health in South Africa, in its policy document, views health as follows:

“as more than simply the absence of disease; health services encompasses promotive, preventative, and curative services; and the crucial role of environmental factors such as clean water and sanitation, housing and education are recognized as fundamental to the improvement of the health status of individuals and populations”

(Nadesan, S, Public Health Law in South Africa, 2000 [3]).

South Africa spends 8.5% of its Gross Domestic Product (GDP) on health; Hungary, 6.0%; Chile, 4.7%; Venezuela, 3.6%; Botswana, 3.3%; and Malaysia, 3.0%. Corresponding life expectancy is as follows: South Africa 63 years; 70 years; 70 years; 68 years; and 71 years, respectively.(Sunday Times- 21/05/1995 ; Hyoungh – Sun Jeong 2005 :1-13; Flood et,al 2003:297-356).

South Africa has been plagued by HIV/Aids and some monitoring agencies reflect that the life expectancy has dropped to 46 years. One needs to be circumspect as this might be a reflection of life expectancy in rural areas and does not translate as being representative of the urban areas of South Africa. Nevertheless the majority of the population lives in rural areas and this could be indicative of the state of health in the country.

South Africa, as we know, has had an entire nation grappling with an unequal and unjust system permeating every facet of society including healthcare. What one is witnessing today is a nation grappling with transformation and trying to change the structural fundamentals of society, a mammoth task by any stretch of the imagination.

When one considers that R34.4 billion is spent on healthcare for 35 million people, who are disease ridden and that the majority of these people are African and rural, whilst R40 billion is spent on just 7 million people who are relatively disease free. (Basset, H, 2002, September, Longevity: 68).

According to the South African government's National Report on Social Development, 1995-2000: 61% of Africans are classified as poor as compared to just 1% of Whites. The unemployment rate for Africans is 42.5% compared to 4.6% for Whites, (Knight, R, July 2001, South Africa: Economic Policy and Development: 2)

Contained in the same paper are more startling statistics from the Congress of South African Trade Unions, (COSATU). Africans make up 76% of the population with their income amounting to 29% of the total South African income; Whites make up less than 13% of the population and their income derived is 58.5% of the total (Knight 2001).

In his seminal book **Public Health Law in South Africa**, Nadesan is of the view that legislation is fundamental in shaping a framework for healthcare. Legislation has at its core the good or welfare of the public. The public interest is the main concern of health related legislation and these laws are applicable to both the public and private healthcare sectors.

Since 1948, Britain has introduced almost every year to 1997 and beyond, health related legislation to reshape its National Healthcare System.

Questions need to be raised as to the formidable contribution of 8.4% of its GDP to healthcare by the South African government and yet life expectancy is falling, and there is a very slow movement towards a National Healthcare System.

In the White Paper for the transformation of the health system in South Africa, the approach government adopted was to introduce a comprehensive Primary Health Care System, and admits that much still needs to be done to transform healthcare in South Africa.

Mention is also made of pooling the resources of both the public and private healthcare sectors. One of the cornerstones of the Reconstruction and Development Programme (RDP) is that the health of all citizens must reflect the wealth of the country. However, intrinsic to health as an old saying goes, **“he who is healthy is rich without even knowing it.”**

One of the determinants of the health of individuals is poverty which appears to be increasing year on year 37% in 1999. It is also well known that the majority of the poor and destitute are Africans, and that South Africa is classified as a middle income country. These statistics become important when one hopes to gain a perspective of healthcare in South Africa.

According to Knight in his paper on **South Africa: Economic Policy and Development**, the government's macro-economic policy known as Growth, Economic and Redistribution (GEAR) is not addressing the economic and job growth or redistribution of income and socio-economic opportunities in favour of the poor. A question one needs to ask is, on what basis is South Africa classified as a middle-income country, when Africans make up 76% of the population and their derived income from the national income amounts to a mere 29%, whilst Whites who make up 13% of the population derive 59% of the total national income.

According to the Health Systems Trust (2002) the percentage contribution from GDP towards healthcare from 1993 to 1998 saw a substantial increase. However, from 1998 onwards there appears to be a decline in government spending on healthcare indicating a shift in budgetary allocations to other areas such as defence. This reduction in contribution by government towards healthcare will significantly affect the goals of the White paper on the

transformation of the health system in South Africa, impeding the progress towards an equitable and accessible healthcare system for all.

According to Navdros, a National healthcare system in most societies is a basic human right, especially in the developing world. Through comparative perspectives, he shows the fallacy that economic constraints do not prevent governments from implementing a National health system. (Navdros' Theory - "Healthcare systems in World Perspectives". Verso Books, 1992).

The National Health Act, 2003, provides a framework for a standard uniform health system within South Africa, taking into account the obligations imposed by the Constitution. However, it appears that government is reprioritising its efforts on other issues.

According to the National Labour and Economic Development Institute (NALEDI), pre-conditions for success in growth in South Africa did not exist, as a result of the government's inheriting a system of gross inequities and high unemployment from the apartheid era. As the proponents of COSATU believe the intentions of government have been scuttled by factors beyond its control, as is evidenced by the inconsistencies between RDP and GEAR.

Let us now examine National Healthcare systems around the world, and view South Africa in its proper context. Every country in the world is different when

one considers economies, geography, demographics, and socio-political histories. For these reasons and more, too many to mention, a country would implement a unique healthcare system to suit its citizens. However, there maybe similarities and as such the importing of ideas and adjusting them to suit a country's needs maybe beneficial for all.

According to the White Paper on transformation of the health system in South Africa, one of the aims of the efforts of a new healthcare system is to unify the fragmented health services at all levels into a comprehensive and integrated National Health System. The approach adopted is to promote Comprehensive Primary Healthcare. The health system will focus on districts as the major sites of implementation and emphasises the primary health care approach. Management of healthcare will be de-centralized to district level to enhance access to services and making primary healthcare available to all.

The priority of primary healthcare will be afforded to maternal, child and women's health. Consideration has been given to the fact that women and children are the most vulnerable. 61% of children South Africa live in poverty and Maternal Mortality Rate is much higher than expected of a country with South Africa's level of income. As is mentioned elsewhere in this research the White Paper on Health aligned itself with the health objectives of the RDP and in addition, government is of the belief that private and public resources should be pooled.

The government acknowledges that the disparities and inequities in healthcare distribution are as a result of the former apartheid policies which entrenched racial, gender, and provincial disparities. Government also believes that the educational status of women is vital for a family's health, therefore in its planning and implementation of equitable healthcare the government is placing special emphasis on women in the planning and implementation of human resource development.

The health sector strategy as set out by government in accordance with the RDP is as follows:

- The health sector must play its part in promoting equity by developing a single, unified health system.
- The health system will focus on districts as the major locus of implementation, and emphasize the primary health care (PHC) model.
- The three spheres of government, NGOs and the private sector will unite in the promotion common goals.
- The national, provincial and district levels will play distinct and complementary roles.

An integrated package of essential PHC services will be available to the entire population at the first point of contact.

The goals and objectives of government in terms of healthcare are:

- Re-organize the department of health, so that it can fulfill its designated functions.
- Integrate the activities of the public and private sectors, including NGOs and traditional healers, in a way which maximizes the effectiveness and efficiency of all available healthcare resources.
- Reorganize the health care system based on primary health care services, with effective referral systems primary, secondary and tertiary levels.
- Increase access to integrated health care services for all South Africans, focusing on rural, peri-urban and urban poor and the aged, with an emphasis on vulnerable groups.
- Establish health care financing policies to promote greater equity between people living in rural and urban areas, and between people served by the public and private health sectors.

- Distribute health personnel throughout the country in an equitable manner.

Provincial health departments, in accordance with the constitution of South Africa will promote and monitor the health of the people in the province, and develop and support a caring and effective provincial health system, through the establishment of a province wide district health system (DHS) based on the principles of primary health care (PHC). For a more concise definition of primary health care and the manner in which the government envisions its roll out to the South African public, attached is a description of the concepts and the different levels at which services are to be established.

PROVINCIAL HEALTH DEPARTMENTS

Role and functions of the provincial health departments

The mission of a provincial health department, as mandated by the Constitution of South Africa within the framework of national policies, strategies and guidelines, will promote and monitor the health of the people in the province, and develop and support a caring and effective Provincial Health System, through the establishment of a province-wide District Health System (DHS) based on the principles of Primary Health Care (PHC).

During the period of transition required for the establishment of a DHS, the provincial authorities (in addition to the functions listed below) will perform functions that will be devolved to the newly-established districts at a later stage. During this critical process, sub-provincial structures such as health regions may be established to assist in carrying out these functions.

The functions of the provincial health authorities will include ensuring:

- a. the provision of regional and specialised hospital services, as well as academic health services, where relevant;
- b. appropriate human resource management and development;
- c. the rendering and co-ordination of medical emergency services (including ambulance services);
- d. the rendering of medico-legal services;
- e. the rendering of health services to those detained, arrested or charged;
- f. the planning and management of a provincial health information system;
- g. quality control of all health services and facilities;
- h. the screening of applications for licensing and the inspection of private health facilities;
- i. the formulation and implementation of provincial health policies, norms, standards and legislation;

- j. inter-provincial and inter-sectoral co-ordination and collaboration;
- k. co-ordination of the funding and financial management (the budgetary process) of district health services;
- l. the provision of technical and logistical support to health districts;
- m. the rendering of specific provincial service programmes, e.g. tuberculosis programmes;
- n. the provision of non-personal health services;
- o. the provision and maintenance of equipment, vehicles and health care facilities;
- p. effective consultation on health matters at the community level;
- q. the provision of occupational health services;
- r. research on, and the planning, co-ordination, monitoring and evaluation of the health services rendered in the province; and
- s. the functions delegated by the national level are carried out.

THE DISTRICT HEALTH SYSTEM

Principles, long-term goals and role of the District Health System

(a) Principles

A national committee established to develop a DHS, comprising representatives of the national and provincial health departments, has agreed unanimously that there are twelve principles with which planners must comply in the development of the DHS. These are:

- i. overcoming fragmentation
- ii. equity
- iii. comprehensive services
- iv. effectiveness
- v. efficiency
- vi. quality
- vii. access to services
- viii. local accountability
- ix. community participation
- x. decentralisation
- xi. (developmental and inter-sectoral approach
- xii. sustainability

(b) Long-term goals and role of the district

The goal outlined in the RDP is to have a single NHS, based on a district health system that facilitates health promotion, provides universal access to essential health care and allows for the rational planning and appropriate use of resources, including the optimal utilisation of the private health sector resources.

The country will be divided into geographically coherent, functional health districts. In each health district, a team will be responsible for the planning and management of all local health services for a defined population. The team will arrange for the delivery of a comprehensive package of PHC and district hospital services within national and provincial policies and guidelines. In time, all district level staff should be employed on the same salary scales and under the same terms and conditions of employment that apply to public sector health personnel throughout the country.

In view of the variety of conditions that exist among and within the provinces, it is unlikely that a single system of governance can be implemented throughout the country. Therefore, three governance options are suggested:

- i. The provincial option, i.e. the province is responsible for all district health services through the district health manager. This option can be exercised where there is insufficient independent capacity and infrastructure at the local level.

- ii. The statutory district health authority option, i.e. the province, through legislation, creates a district health authority for each health district. (This option can be exercised in instances where no single local authority has the capacity to render comprehensive services.)
- iii. The local government option, i.e. a local authority is responsible for all district health services. (This option can be exercised if a local authority, whose boundaries are the same as that of a health district, has the capacity to render comprehensive services.)

Implementation strategies

Each province will be subdivided into a number of functional health districts:

- a. The district will serve both as provider and purchaser of health services, and will select the appropriate strategy on the basis of equity, efficiency and assessment of local conditions.
- b. Peri-urban, farming and rural areas will fall within the same health district as the towns with which they have the closest economic and social links. The fragmentation and inequity created by the past practice of separating peri-urban and rural health services from the adjacent municipal health services must be eradicated.

- c. There will be parity in salaries and conditions of service for all public sector health personnel throughout the country, which include appropriate incentives to encourage people to work in underserved areas. This is essential in order to rationalise services, overcome fragmentation and promote equity, particularly between metropolitan, urban and rural areas.
- d. Financing mechanisms or formulae will be devised, to ensure that district level health services are financed in an equitable and sustainable manner.

The establishment of the DHS is at the core of the entire health strategy, and its rapid implementation, therefore, is of the highest priority.

Functions of a health district

This level of the health care system should be responsible for the overall management and control of its health budget, and the provision and/or purchase of a full range of comprehensive primary health care services within its area of jurisdiction. Effective referral networks and systems will be ensured through co-operation with the other health districts. All services will be rendered in collaboration with other governmental, non-governmental and private structures.

Functions at this level are as follows:

(a) Health care

- i. Ensuring health promotion services;
- ii. providing for collaboration with other sectors of Government and NGOs in promoting health and ensuring the rendering of health services in the health district;
- iii. providing for community participation in health promotion and health service provision;
- iv. ensuring the availability of a full range of PHC and other relevant health services in communities, clinics, community health centres, district hospitals and other facilities;
- v. ensuring primary environmental health services, the promotion and maintenance of environmental hygiene; the prevention of water pollution; enforcement of environmental health legislation, i.e. regarding sanitation, housing, smoke, noise, fitter, food hygiene and occupational hygiene, and the identification and control of local health hazards;
- vi. rendering essential medico-legal services; and
- vii. ensuring services to those arrested and charged, in collaboration with the relevant authorities.

Note: this package will be subject to the outcome of negotiations between the province and a municipality in terms of the constitutional right of municipalities to render municipal health services.

(b) Administrative, financial and support services

- i Ensuring the provision of support services essential to the rendering of health services, including: the accommodation for staff, where necessary; appropriate facilities for the rendering of maternal and mental health services, essential medicines, essential diagnostic services, transport; and the maintenance of equipment, facilities and other assets,
- i. establishing and managing the health district's budget in accordance with national and provincial policies and guidelines, and purchasing services as appropriate, and
- ii. ensuring the promulgation of health by-laws.

(c) Planning and human resources

Monitoring and evaluating health and health service provision by:

- i. gathering, analysing and managing health information at the district level;

- ii. providing for appropriate human resource development; and
- iii. ensuring the performance of any other health function or duty assigned to the health district.

INTEGRATING THE PUBLIC AND PRIVATE HEALTH SECTORS

(a) Integration of private practitioners

Private health practitioners should be integrated with the public sector with regard to the provision and management of services. The central thrust being to enhance the capacity of the NHS to deliver affordable quality health care to all citizens of South Africa.

(b) Implementation strategies

- i. The policy should apply to all private practitioners including private midwives, general medical and dental practitioners, specialist obstetricians and gynaecologists, paediatricians and private pharmacists.

- ii. Services delivered by occupational health practitioners, and prison and military health authorities, should be subject to the same principles.
- iii. In the delivery of a comprehensive and integrated Maternal, Child and Women's Health (MCWH) service, where an MCWH management team will oversee both public and private sector delivery at each organisational level.
- iv. Private practitioners will be required to meet national training standards in relation to the services rendered at each level of care.
- v. Private practitioners will be encouraged to assist in the development of and follow standardised clinical management protocols.
- vi. Both the public and private sectors will be required to provide information to the National Health Information and Audit Systems.
- vii. To avoid duplication of expensive equipment within certain geographic areas, all equipment should be purchased through a system of control, be used optimally by both the public and private sectors, and be properly maintained.
- viii. Provincial health departments and health districts will be responsible for purchasing services from the private health sector and accredited providers, where required.

(c) Role of non-governmental organisations

Non-governmental organisations (NGOs) should continue to play an important role in the delivery and management of health services.

INVOLVING THE COMMUNITY

All South Africans should be equipped with the information and the means for identifying behavioural change conducive to improvement in their health.

Much of the progress made in improving the health status of individuals depends on the existence of healthy environments and lifestyles. It is crucial to involve individuals, families and communities in this process.

(a) Implementation strategies

- i. The National Health Service should take advantage of all available opportunities to provide individuals, communities and the public at large with relevant information on healthy behaviour.
- ii. The Department of Health should work in close collaboration with all social groups, especially women's and youth groups, to support the acceptance of and response to messages related to healthy behaviour.

- iii. The Department of Health should promote and support legislation and policies for creating an environment that is conducive to healthy behaviour.
- iv. The Department of Health should seek to establish close collaboration with the media to facilitate the wide dissemination of health-related information and promote positive role-models.
- v. The Ministry of Health should work in close collaboration with the Ministry of Education and other social ministries, to provide them with the technical support required to develop their potential in health promotion fully.
- vi. Clinic, health centre, hospital and community health committees should be provided with the required technical support and motivation to become advocates of positive behavioural change in the communities they represent.
- vii. The Minister of Health should mobilise political leaders at all levels to lend their support to health promotion efforts.

People should be afforded the opportunity of participating actively in various aspects of the planning and provision of health services

In accordance with the democratisation of South African society, mechanisms for the participation of the people in the National Health System will be established at all levels.

(b) Implementation strategies

- i. Clinic, health-centre and hospital and community health committees should be established to permit service users to participate in the planning and provision of services in health facilities.
- ii. Each community should know which CHC is responsible for providing it with the essential PHC package; therefore, the catchment area of each CHC must be clearly defined and known to all partners.
- iii. The essential PHC package should be negotiated between the providers and the communities, to ensure that priorities perceived by the communities are addressed and that the communities have a clear understanding of their entitlements.
- iv. The communities should elect the individuals who will represent them with regard to health matters.
- v. The roles and powers of elected representatives should be clarified.
- vi. Simple community-based information systems should be established by communities with the support of the health staff, to provide the information needed for the identification of priorities, the monitoring of progress made towards locally-established objectives and decisions on actions to be taken.

- vii. Representatives of the communities should play a pivotal role in identifying underserved groups, and establish strategies to reach them in partnership with the primary health team.
- viii. Women should be enabled and supported in playing a major role in local health committees.

The Department of Health should provide the public with regular updates on progress, results and emerging issues related to its work, and should ensure that people participate in the development of national policy

The NHS is undergoing major changes which are bound to raise questions and create anxieties. Therefore, to facilitate the process, promote consensus and engender support, consultation must be extensive, the rationale behind changes clearly explained and regular updates on progress made widely disseminated to the public.

(a) Implementation strategies

- i. Periodic national health summits should be established as a mechanism for public participation, make policy recommendations and identify new areas requiring attention. Similarly, provincial and district health summits should be held to review the progress made and plan improvements to the system, as well as structure local inputs to the national summits.
- ii. National, provincial and district annual reports should be compiled and disseminated to the public.

- iii. The national, provincial and district health authorities should develop a mechanism for responding timeously to enquiries raised by the public.
- iv. The Minister of Health should provide parliamentarians and other political representatives with the information they require to respond adequately to questions raised by their constituencies.
- v. Officials of the Department of Health should seek opportunities to present and explain issues of concern to the public.
- vi. The NHS should make use of appropriate mechanisms to measure the level of consumer satisfaction with the services provided, and disseminate the results.

PRIMARY HEALTH CARE

The priority of the National Health System

The new South African health system adopts the PHC approach because this approach is the most effective and cost effective means of improving the population's health. The approach involves a health system led by PHC services, which are at the base of an integrated district health system.

Definition of the PHC package

The PHC package will comprise the services listed below. The provision of these services will be promoted and evaluated by district health teams and relevant support personnel. The actual scope of the package of services will be determined by the available resources and will be implemented on a sustained and incremental basis over a 10 year period.

These services are likely to be provided at the district level, but may be in part or completely funded from sources other than the health vote.

Public-private mix at the district level

District Health Authorities will supervise and allocate budgets to public providers and, where appropriate in the case of personal ambulatory care, purchase services from accredited private providers. There will thus be an opportunity for the ultimate emergence of some form of provider competition, especially in densely populated areas of the country. These arrangements will encourage improved governance, both at the district and provider levels.

Because of potential problems envisaged with the too rapid introduction of accredited private providers, public facilities will remain the dominant PHC providers funded by the government for the next few years. Accredited private providers will be introduced gradually, particularly in currently under-served areas. Priority will be given to sessional work by private providers in public facilities. In accordance with the principle of devolution of authority to the district level, DHAs will themselves make decisions regarding the appropriate public-private provider mix in their districts at different points in time.

Where full and/or part-time practitioners are in short supply, private practitioners' services will be used through referral contracts, and patients will be referred to a general practitioner by a PHC nurse in the public. The overall effect of these reforms will be to facilitate the emergence of flexible and creative arrangements between DHAs and local practitioners and to maximise private doctors' contributions to the public health system.

As was stated elsewhere in this discussion, in a review by Health Systems Trust, mention was made that the government's contribution to health is reducing year on year. Richard Knight comments in his paper on South Africa: Economic Policy and Development, July, 2001,

“ perhaps the most poignant challenge facing South Africa is how it will balance fiscal policy and it's goal of attracting foreign investment with the pressing needs of it's people for jobs, housing, land, education and health care- defined as rights in its Constitution”

CHAPTER 2

LEGISLATION:

When is a right a legal right as per our constitution? This was a contentious issue as the case of Soobramoney versus the Minister of Health (KWA-ZULU NATAL) has shown almost conclusively.

Sections 26 and 27 of the Bill of Rights guarantees access to health care, yet in this case, Soobramoney was denied this right. What is apparent from these provisions is that the obligations imposed on the state in regard to access to health care are dependent upon the availability of resources and as such the rights given to citizens become limited by reasons of lack of resources.

Soobramoney died shortly after this case was decided by the Constitutional Court in 1997. He was declined renal dialysis. It seems that the concept of the right to life becomes blurred. Soobramoney's case raises a number of concerns, despite the concurrence of Judges Chaskalson, Sachs and Madala of the Constitutional Court of South Africa. Their decision was unanimous in upholding the High Court's decision to deny Soobramoney the right to access renal dialysis.

These Judges in their wisdom elaborated on the limitations of rights of an individual especially if the State has scarce resources. In this context it appears that rights are unlimited in the Private health sector for as long as a person can afford it. No sooner the individual enters the domain of the public sector he/she may have their right to access health care curtailed if the State is lacking in resources. This was the case for Soobramoney who found himself, at age 41, after initially paying for renal dialysis in the private sector and then finding himself unable to continue paying, was forced to seek help from the public health care sector.

In Chapter 35 of the Judgement handed down by the learned Judges of the Constitutional Court, Judge Chaskalson stated,

“I should add that I do not consider it appropriate to comment on the attitude of the private medical sector to Continued Ambulatory Peritoneal Dialysis (CAPD) treatment. No evidence was placed before us in that regard and there is nothing in the papers to show that patients treated privately do not receive proper advice in regard to the availability, risks and costs of such treatment”.

(ref: JUDGEMENT in the Constitutional Court of South Africa - THIAGRAJ SOOBRAMONEY(appellant) versus MINISTER OF HEALTH KWAZULU-NATAL) (respondent): Chapter 35.

Does the above statement by the learned Judge infer that if evidence by an expert from the private health sector was forthcoming, there might have been a different judgement, possibly in favour of Soobramoney?

Further if the Constitution is futuristic as Judge Chaskalson suggests, then at some stage resources might become available, in which case, others in Soobramoney's predicament would very well benefit and have their right to access health care granted. For as long as there are inadequate resources this right will be limited.

Other contentious issues are the ethical and moral considerations that this case brings into sharp focus. The public health sector engages in definite rigid criteria for patients to be admitted for end stage renal dialysis whilst the criteria in the private health sector are not as strict, depending on whether the patient can afford continued treatment.

(ref: Paragraph 48 of the Judgement against Soobramoney)

The above implies that there is a distinction between the private health sector and the public health sector as regards their consideration of ethical and moral issues.

The stricter the criteria, the more ethical and moral, the more relaxed the criteria, the less ethical and moral. Perhaps if a uniformed health system in

the form of a National Health System is established in South Africa, these dilemmas would be eradicated.

In the case of the TAC versus the MINISTER OF HEALTH, Chapter 22.11, CASE CCT8/02 , the affidavit signed by the chairperson of the TAC for the applicants, reads as follows: **"there is no rational or lawful basis for allowing doctors in the private sector to exercise their professional judgement in deciding when to prescribe Nevirapine, but effectively prohibiting doctors in the public sector from doing so"**

Since 1994, responsibility for health care in South Africa has largely been the domain of provincial governments. These provincial governments have established their own legislation, based on the White Paper for the Transformation of Health Care in South Africa.

During the apartheid era, the health system was unequal, dislocated and unjust. There were 14 different health departments with duplicated services for each racial group: 10 bantustan health departments and 3 "own affairs" health departments for the whites, coloured and Indian population groups. The problems inherited from the apartheid system were enormous, however since 1994, South Africans have seen some major strides in the development of socio-economic rights as is supported by the South African Constitution, the supreme law of the land and which states that every South African has

the right to:

'access to healthcare services, including reproductive care'

(section 27)

And that children have the right to:

'basic nutrition, shelter, basic healthcare services and social service'

(section 28)

In addition, everyone has the right to an environment which is:

'not harmful to health or wellbeing'

(section 24)

The White Paper for the Transformation of the Health System in South Africa is a policy document which outlined the principles upon which a Unified National Health System in South Africa will be based .
(Department of Health 2003).

The subsequent National Health Bill was passed by the Parliament of South Africa and enacted. The cornerstone of this Act takes into account the obligations imposed by the Constitution and other laws on National, Provincial and Local Governments with regard to health services.
(Refer to the preamble of the National Health Bill [reference B32B – 2003][ISBN062133889 3].

The White Paper for the Transformation of the Health system in South

Africa endorses that the thrust of a health system in South Africa will be Comprehensive Primary Health Care.

The Primary Health Care approach emphasises general health care rather than curative care which was the case during the apartheid era.

The chapter examined the seminal legal cases of Soobramony versus the Department of Health /KwaZulu Natal and the TAC versus the National Minister of Health in the Constitutional Court , as well as existing legislation on the health care system.

The next chapter will examine the case of South Africa in a comparative perspective.

CHAPTER 3

DEVELOPMENTS IN SOUTH AFRICA

According to the White Paper on the Transformation of Health care services in South Africa, health care will be based on the principles of the Primary Health Care approach and the District Health system.

The restructuring of the health sector has the following aims:-

- (a) to unify the fragmented health services at all levels into a comprehensive and integrated National Health system. A district health system is seen as the best way to achieve this;
- (b) to reduce inequalities in health service deliveries;
- (c) to mobilise all stake holders, including the private sector, NGO's and communities.

The primary health care approach to health emphasises general health care rather than curative health care. The approach is based on the following principles:

'Bringing health closer to the people', p 26 – Local government and the

District Health system. March 2001, Health Systems Trust.

The Primary Health Care approach involves the entire health system at all levels. It has at its core development, where communities could be partners in health care, resources and finances would be shifted from high-tech tertiary hospitals to primary level services and specialist doctors would play a supportive role to nurses working in clinics. This marks a shift towards equity in health.

Since 1993, when the Interim Constitution was adopted for South Africa, local government has been going through a process of transformation. The transitional phase ended with local government elections in 2000.

The national government has made a policy decision to have strong local government in South Africa. The apartheid system was unjust, unequal and repressive as regards the social, economic and political lives of Black South Africans and who were excluded from national and provincial government. Black municipalities had no power and were mere administrative agents of the white provincial governments.

Between 1996 and 2000 the transformation process continued. However, the system of governance was still fragmented with too many different types of structures. The Municipal Demarcation Board (MDB) was set up to re-draw all the areas of local government.

According to Dr Abe Nkomo, chair of the National Assembly Portfolio Committee on Health, in the forward of "Bringing health closer to people", 'Local Government and the District Health System', published by Health Systems Trust, March 2001, **"the demarcation of the municipal boundaries and the local government elections in 2000, signalled a critical step towards achieving this goal"**

As far as health care is concerned, broad guidelines exist i.e. the Constitution states that municipal health services are the responsibility of local government. In addition, it says that health services can be handed over from national or provincial government to a municipality, if that municipality has the capacity to assume this responsibility.

One of the central points of the District Health System is to overcome fragmentation and has as its functions to:

- (i) ensure health promotion service,
- (ii) provide for collaboration with other sectors of government and NGO's in promoting health and ensuring the rendering of health services in the health district,
- (iii) ensure the availability of a full range of Primary Health Care and other relevant health services in communities, clinics, community health centres, district hospitals and other facilities,

- (iv) provide for community participation in health promotion and health service provision,
- (v) ensure primary environmental health services:
 - *the promotion and maintenance of environmental hygiene;
 - *the prevention of water pollution;
 - *enforcement of environmental health legislation regarding sanitation, housing, smoke, noise, food, and occupational hygiene and the identification of local health hazards,
- (vi) render essential medico-legal services, and
- (vii) ensure services to those arrested and charged, in collaboration with the relevant authorities.

(White Paper for the Transformation of the Health Care System in South Africa, Department of Health 2003).

The transformation of local government has moved steadily and is simultaneously developing within the broad outlines of the White Paper on Health in South Africa.

Some of the challenges facing Local government include assuming some

of the provincial government's responsibilities for the delivery of health care.

Presently there are problems facing the provincial governments. Some are better resourced than others and in the sphere of local government, some municipalities are having difficulty in funding themselves because of their impoverished populations. Large numbers of people find it difficult or are unable to pay for their rates and services. In addition, these areas lack the capacity and financial management to do justice to an equitable redistribution of resources.

In the Private Health sector, some improvements by way of legislation have given momentum to provide social health insurance for employed but uncovered workers. This programme aims to bring in 15 million people who are employed but are not members of medical schemes. Currently, about 7 million people are covered by private medical aid schemes. The proposed establishment of the public service medical scheme will gain momentum in 2005 (Health Systems Trust 2002).

The Board of Healthcare Funders of Southern Africa (BHF) announced in 2001 a campaign to encourage medical aid schemes to provide comprehensive HIV/AIDS benefits. There has been some progress in this

regard as medical aid schemes and other insurers have been compelled to offer benefits to HIV/AIDS sufferers.

A Witwatersrand University Aids law project claimed, (Cheap Anti-Aids drugs are legal – Wits: Business Report: Sunday Tribune, May 22, 2003), that Alec Erwin, Minister of Trade and Industry, said, at a World Trade Organisation (WTO) summit, that disagreement on how to protect intellectual property rights stood in the way of South Africa becoming a significant producer of cheap anti-retroviral drugs.

Jonathan Burger, a senior researcher with this project at the Centre for Applied Legal Studies, disagreed. He believed that the Minister of Health, Manto Tshabalala-Msimang, and Alec Erwin could take swift action, using their powers under the Patents Act to issue compulsory licences for the local production of generic medicines. Producing generics is the best way to do this as the country does not have the resources for original research, but can produce cheap, good quality drugs. The Indian pharmaceutical industry employs millions of people and ensures that essential drugs are available to its vast population at affordable prices.

According to Census 2001, South Africa's population grew by 10% since 1996. The population in 2001 was 44.82 million, and KwaZulu-Natal's unemployment rate stood at 48.7%, with Africans at 50.2%; Coloureds at 27%; Indians at 16.9% and Whites at 6.3% .

New regulations, under the revised Pharmacy Act, have opened the doors for the ownership of community pharmacies and by non-pharmacists thus seeking to create a balance of interests between incentivising corporate participation and protecting the rights of current licence holders, the communities they serve and the broader local healthcare environment.

This Act serves to redress inequities in service in service provision and access to healthcare by ensuring an adequate and reliable supply of safe, cost effective drugs of an acceptable quality.

The Medical Aid Schemes Act stipulates that vulnerable groups such as the elderly and people with chronic illnesses must have cover. The Act made open enrolment by medical aid schemes compulsory. This means that no-one can be refused membership by an open medical scheme. Also, medical schemes cannot penalise a potential member by increasing his/her contribution. The only discriminating criteria for membership are income and the number of dependents. In the private sector, this move has significantly helped people with ailments to become members of medical schemes and receive healthcare for as long as they can afford to pay.

South Africa has two primary levels of private health cover i.e. via medical aid schemes and health insurance policies. There is a fundamental difference between these two covers according to an article by Laura du

Preez in the **Saturday Independent**, August 30, 2003, p. 32. In this she informs us that according to the Medical Schemes Act, medical schemes have to accept anyone to their membership, charge all members the same contribution regardless of their age or state of health. Health insurance policies, on the other hand, may place restrictions and charge people who pose a greater risk higher premiums, based on regulations in the Long Term and Short Term Insurance Act.

The Medicines and Related Substances Control Amendment Act, Implemented in May 2004, made it compulsory for pharmacists to offer patients generic drugs in place of the patented original products. The patient however has the final say as to whether to purchase the generic substitute or the original. In the case of the latter, the patient will have to pay a higher price.

The use of generics in the private sector is approximately 20% of the private sector market valued at R12 billion. An increase in usage by even 1% will create more savings for the patient. It seems that the South African health system needs to seriously re-examine ways of creating a cost effective medicine industry, and in so doing will make healthcare accessible and more affordable to all.

South Africa's quality control for drugs is among the best in the world. What is needed is expansion and capacity-building for the drug industry which will create less reliance on multinationals.

According to Dr Ayanda Ntsaluba, Director General of Health, in a newspaper report (Sunday Times, August ,2003) about 7 million South Africans had access to better primary healthcare since 1995 with the building of more than 700 clinics. However, according to research conducted by the School of Public Health at the University of the Western Cape, areas with the greatest needs received the least resources.

Primary healthcare expenditure per capita remains unequal between provinces, according to research conducted by the University of Cape Town's Health Economics Unit. Poorer provinces were spending R75-00 per capita whilst others were spending R246-00 per capita in 2001/2002. Discrepancies between districts were also great with some spending R42-00 per capita compared with R389-00 by others.

Dr Ruth Rabinowitz, (IFP MP), and spokesperson on health for her party, stated in a letter to the editor (ref. Sunday Tribune, August 31, 2003) that the Health Bill has flaws in that in its aim to regulate the health service, Government is poised to force people to do what is good for government. She suggests that incentives be offered to personnel to render their services

to outlying areas; that partnerships be forged between private health groups and government to offer services to rural people, through a system of government contracts.

The certificate of need is a very controversial one in that the health ministry lacks the systems to determine this, and as a result the issuing of these certificates is based on inaccurate information in a number of instances.

Dr Rabinowitz further states that too much power is vested in the Minister of Health as is contained in the Health Bill. Health services, she adds, must be regulated, not for total control but to ensure compliance with minimum standards in the public and private health sector.

The Health Bill, as seen by Dr Rabinowitz, promotes undemocratic practices that expose the public to a healthcare system open to corruption, mismanagement and further deterioration.

In an article "Doctoring up South Africa's Healthcare System" by Adele Shevel, (Sunday Times, Business Times, 1st February 2004) the following aspects are raised about the Department of Health's 2 phase social health insurance plan.

It is intended that this health insurance provide for 65% of the population's healthcare needs. The Health Equalisation Fund heralds changes to the medical schemes. Schemes with younger, healthier members will cross-subsidise those with older, more sickly members, because government's intention is that healthy people to assist the aged with their disproportionate costs.

Employers are already reducing their contributions to the healthcare of their employees, with implications for all wage earners above a certain threshold. Employees are digging deeper into their pockets due to medical inflation being higher than consumer inflation. Proponents of social health insurance want to fund the initiative through a payroll tax. The Health Department's plan is to have all government employees covered by a single fund. Presently, there are 80 schemes servicing the civil sector. Government intends to bring 1.5 million new members into the private healthcare system.

Another phase involved in social health insurance is to introduce voluntary cover to low-income earners, who are expected to number about 5 million. Only the lowest income earners and those without income will remain within the public sector.

The Congress of South African Trade Unions (COSATU), believes that South Africa needs a National Health Insurance to cover a greater number of people, rather than a Social Health Insurance that covers a selected number

of people. Private hospitals in South Africa are amongst the best in the world, and it won't be long before this sector is regulated. In terms of Social Health Insurance proposals, medical schemes will have to offer a basic package of benefits. This will include primary healthcare and the Risk Management fund (REF) described earlier, and will equalise the cost of providing the basic benefit package between schemes and will ensure that schemes with older, sicker members do not pay more than others for those basic benefits. The current tax subsidies for medical scheme members and which favour higher income earners will be revised in favour of direct government subsidy to benefit everyone equitably.

Higher-income earners will subsidise the cost of the basic benefits package of the lower-income earners. Members will pay income-based contributions for the basic benefits package as a tax that will be paid into the Risk Equalising Fund (REF). Medical scheme membership will be made compulsory for those who can afford it.

The scope of traditional healers and medicine is gaining momentum in South Africa and legislation has been promulgated to include traditional into the fold of healthcare services.

South Africa has some 200,000 traditional healers and only 23,000 aliopathic doctors. Traditional medicine is estimated to be worth R2,3 billion per annum. If this industry is streamlined it could become a major one in South Africa.

Patience Koloko, president of the Traditional Healers Association of South Africa believes there can be a partnership between traditional healers and aliopaths. She cites the example of utilizing scans and X-rays to diagnose and prescribe medicines accordingly. Most of the herbs found in the medicines used by traditional healers and aliopaths are the same, but are used differently. Many of the medicinal plants are already being used by international drug companies. Traditional healers use them in powdered form while laboratories in drug companies present them in tablet form (ref.: Sunday Times KZN, August 31, 2003, Marjorie Copeland).

DEVELOPMENTS IN OTHER COUNTRIES

In most developed and developing countries, healthcare is the number one issue on the minds of citizens and government officials. Even though food, housing, education, energy and other items also top the list of critical problems facing countries, healthcare still stands out as an important fundamental issue.

HEALTHCARE IN BRITAIN

Health care in Britain has gone through a long historical process that has led to the present state of affairs.

June **1941**. Sir William Beveridge appointed to chair an inter-departmental committee to look into existing national insurance schemes and allied services and make recommendations.

June **1942**. The Beveridge report published. Identified health as one of three basic services (with family allowances and full employment) which are a necessary prerequisite to social security).

1944. White Paper 'A National Health Service' published. Proposed local bodies to administer local authority hospitals.

March **1946**. Aneurin Bevan, Minister of Health, published a further White Paper on establishing a national health service. NHS Bill published proposing nationalization of hospitals and a tripartite structure of services.

May **1946**. Spens Report published, recommended central pool for GP payments.

6th November **1946**. National Health Service Act became law. It promoted 'the establishment in England and Wales of a comprehensive health service designed to secure improvements in the physical and mental health of the people of England and Wales and the prevention, diagnosis and treatment of illness' and the setting up of the Central Health Services Council to advise the Minister.

5th July 1948. National Health Service established.

May **1951.** NHS charges introduced for the first time – £1 for spectacles and half the actual cost for a pair of dentures.

June **1952.** Charges introduced for dental treatment – flat rate fee £1 and drugs (1 shilling (5p)) per prescription form.

January **1956.** Guillebaud Committee reported on NHS finances and defended both costs and structure.

1959. Mental Health Act 1959 (Mental Health (Scotland) Act 1960) abolished distinction between psychiatric and other hospitals allowing admission and discharge to any hospital without formality. Ended need for chief officers of psychiatric hospitals to be medically qualified. Encouraged the development of community care.

November **1968.** Ministries of Health and Social Security amalgamated to form Department of Health and Social Security (DHSS).

July **1973.** The National Health Service Reorganisation Act given Royal Assent on the 25th Anniversary of the establishment of the NHS.

April **1974.** NHS re-organised:

Local authority involvement in health care restricted to environmental health.

Community health services including district nurses, immunization and vaccination,

School health and ambulance services transferred to health authorities.

Regional Health Authorities Created to manage 90 area health authorities managing 206 district management teams.

Executive Councils were effectively retained for GP services with the creation Of Family Practitioner Committees coterminous with and set up by the area health authorities.

Consensus management introduced .

Teaching hospitals integrated into unified structure

Community Health Councils formed.

New planning system of 10 year strategic plans and three year operational plans.

1976. National Health Services Act 1976 came into force, aimed at reducing numbers of pay beds in NHS hospitals and allowing some private practice by consultants.

May 1976. Royal Commission on the Health Service (announced previous October) established.

July 1979. Royal Commission reported but Government later published its

own plans for NHS reorganization.

December **1979**. DHSS published 'Patients First' in response to the Royal Commission, strengthening management at the local level, removing the area tier and establishing district health authorities.

1980. The Health Service Act became law:

Dissolved the Central Health Services Council

Dissolved Health Services Board which had been formed to phase out private beds in NHS hospitals

Disbanded the area health authorities.

Created 192 new district health authorities in their place.

April **1982**. NHS re-organised from 1979 White Paper and 1980 Health Services Act: area tier abolished .

District became main operational authorities.

'Unit established as the local management tier.

Professional consultation and planning procedures pruned.

October **1983**. The Griffiths Report on NHS Management published. Led to the introduction of general management in the NHS.

1984. United Kingdom Central Council (UKCC) and National Board of

Nursing, Midwifery and Health Visiting set up. The UKCC is the statutory Regulatory body and the National Boards take responsibility for nurse education.

January **1988**. The Prime minister announced a fundamental review of the NHS.

March **1988**. The Prime Minister's special advisor in Health and social care, Sir Roy Griffiths, presented 'Community Care: Agenda for action' report to Secretary of State for Health.

July **1988**. DHSS split into separate departments for health and social security.

January **1989**. 'Working for Patients' white paper published, proposed reform of NHS including internal market.

May **1989**. NHS Management Executive established.

November **1989**. 'Caring for People. Community Care in the Next Decade and Beyond' published.

November **1989**. National Health Service and Community Care Bill published to give legal effect to 'Working for Patients and Caring for People'.

June **1990**. National Health Service and Community Care Bill received Royal Assent.

July **1990**. Secretary of State announced phased implementation of 'Caring for People'

July **1990**. Regional Health Authorities reconstituted as part of 'Working for patients' with smaller memberships including RHA executives.

September **1990**. District health authorities and special health authorities reconstituted.

September **1990**. Family Practitioner Committees reconstituted as Family Health Services and made accountable to Regional Health Authorities.

April **1991**. 'Working for Patients' and part of 'Caring For People' reforms came into effect.

NHS internal market began .
(DHAs purchased services for their resident populations)first wave trusts and
306 GP fun-holders began to operate

Local authority inspection units for residential homes became operational .

Mental illness specific grants were introduced

April **1991**. Department of Health launched Comprehensive 'Research and Development Strategy for Health'.

October **1991**. Patients' Charter launched.

January **1992**. Extension to the GP Fund-holding scheme announced.

April **1992**. Second wave trusts and GP fund holders became operational

Community care planning arrangements had to be in place.

Regions began to operate health information services in response to Patients' Charter.

July **1992**. 'Health of the Nation White Paper published.

1993. Implementation of National Health Service Community Care.

Funding transferred from Department of Social Security to local authorities for those receiving residential and nursing home care.

April **1993**. Primary Care Charter Initiative – encouraged GPs to develop their own practice charters.
charters.

April **1993**. third wave of NHS trusts and GP Fund-holders became operational.

January **1994**. 'Changing Childbirth' accepted as Government policy.

March **1994**. A fourth wave of NHS trusts and GP Fund-holders became operational, brought the total number of trusts to 419.

June **1994**. Publication of the first NHS comparative performance tables.

November **1994**.

'A Framework of Local Community Care Charters in England' launched as a guide to local authorities in preparing Community Care Charters.

January **1995**. Updated Patients' Charter – introduced additional rights and more challenging national standards.

April **1995**. New accountability framework – provides the basis for the further development of effective partnerships between health authorities and general practitioners and between these parties and other agencies both within and outside the NHS.

April **1995**. New code of practice on openness for NHS published.

April **1995**. Two new codes of conduct and accountability issued to NHS boards – they defined the roles and responsibilities for which the NHS boards and their chairmen will be held to account by the Secretary of State.

April **1996**. The Carers (Recognition and Services) Act 1995 came into force. Regional health authorities abolished.

Eight regional offices of the NHS Executive established through the amalgamation of previous district health authorities and family health services authorities . 100 new health authorities set up. New complaints system introduced . Second wave of total purchasing fund.

July **1996**. The Community Care (Direct Payments) Act 1996 received by

Royal Assent.

October **1996**. Publication of White Paper: 'Primary Care: The Future – Choice and Opportunity'.

November **1996**. Publication of White Paper: 'A Service with Ambitions'.
Publication of Primary Care Bill.

December **1996**. Publication of second White Paper: 'Primary Care: Delivering the Future'.

February **1997**. Publication of Green Paper on mental health services.

(Morris et al, 2004; Benzeval and Judge 1996: 33-40; Department of Health 2000; Gravelle et al, 2003 :985-1004).

George Monbiot – Guardian 30 September 2003

If that sounds like an exaggeration, take a look at the new “diagnosis and treatment centers” (DTCs) whose private operators the health secretary John Reid listed a fortnight ago. These are the clinics to which hundreds of thousands of NHS patients will now be sent for routine operations. Reid insists that the private operators will provide cheaper services than the NHS, cut waiting lists and offer patients a choice of where and when they have their operations. All these claims already turn out to be untrue. But they will succeed in destroying the last pretence that the health service is not being

privatised (Proper 1998; Smaje and Le Grand 1997:485-496; Sutton et al, 2002).

HEALTH CARE IN THE UNITED STATES OF AMERICA:

The need for a comprehensive and pragmatic approach to the issue of the uninsured is underscored by a Census Bureau report released in 2004 showed that the number of Americans without health insurance increased by 1.4 million between 2002 and 2003. The overall number of people with health insurance cover increased by 1.0 million in 2003.

"The President is working to expand access to health care for all Americans, beginning with those who need it most," Secretary Thompson said. **"His initiatives are expanding access to medical care for children and lower-income Americans, as evidenced by his successful expansion of community health centers, children's health coverage and Medicaid programs."**

"Yet, the President knows more needs to be done, particularly when it comes to lowering the cost of health care so that it is accessible to more people," the Secretary added. **"The President is investing significantly in health care technology to bring down the cost of delivering medical care, and he continues to press for medical liability reform as frivolous lawsuits and defensive medicine continue to drive up health care costs."**

Secretary Thompson added that millions are living healthier lives because of President Bush's leadership. Administration initiatives are working to provide Americans with better access to vital services, such as:

- **Community health centres** - Three million more Americans have access to health care as a result of the President's five-year plan to fund 1,200 new and expanded health center sites to serve an additional 6.1 million people by 2006. These health centers provide direct medical care, particularly for lower-income and uninsured Americans (Brown 2003:52-57).
- **Medicaid and State Children's Health Insurance Program** - HHS has helped states extend coverage to an estimated 2.6 low-income Americans by granting states waivers and approving state plan amendments to these programs. Overall, under the President's leadership, SCHIP enrollment has hit an all-time high of 5.8 million children in 2003, up 1.2 million since 2001. And the program has the potential to cover even more children.
- **High-Risk Pools** - In 2003, HHS provided states with \$23 million in grants to help 18 states create these high-risk pools that provide coverage for people too sick to afford conventional insurance.
- **Medicare** - More than 4 million seniors are saving with Medicare prescription drug cards for the first time. In 2006, more than 40 million seniors will have access to prescription drug coverage for the first time under Medicare (Brown 2003; Deber 2003 :20-25).

- **Health Savings Accounts** - The new Medicare law establishes these flexible, affordable accounts. Americans who set up Health Savings Accounts along with the purchase of a low-cost, high-deductible health care plan can save tax-free money to pay routine medical expenses and future health care costs. President Bush has proposed allowing individuals who establish an account to also deduct the premiums they pay for their high-deductible policies.
- **Hospital Discounts** - The Bush Administration also is investing nearly \$25 billion annually to help hospitals bear the cost of the poor and uninsured, while making it clear to these hospitals that they can, and should, provide discounted care to the uninsured or underinsured.
- **Lower Drug Prices** - The Department introduced new regulatory processes that will help get low-cost generic alternatives to consumers more quickly. This initiative is estimated to save Americans as much as \$35 billion over the next 10 years (Szasz 2001)

Additionally, Secretary Thompson called on Congress to approve the President's proposals to make health care more affordable and accessible, including:

- **Tax Credits** - President Bush has proposed to establish refundable tax credits of up to \$3,000 for families and \$1,000 for individuals to help low-income workers buy health insurance coverage. If approved by Congress,

this proposal would provide coverage for an estimated 4 million Americans (Brown 2003).

- **Association Health Plans (AHPs)** - President Bush has proposed allowing small businesses to band together and negotiate lower health care premiums for their workers and families - just like big businesses.
- **Medical Malpractice Reform** -- President Bush believes common-sense reforms to medical liability law will increase access to quality, affordable health care for all Americans, while reducing frivolous and time-consuming legal proceedings against doctors and health care providers that are driving good providers out of local communities across the country and raising health care costs for all Americans (OECD 2000; OECD 2003).
- **Investing in Technology** - The President's FY '05 budget doubles the amount of funding for demonstration projects for broader adoption of health IT systems in communities and states. The President announced a goal of moving to personal electronic records for most Americans in the next ten years. By creating an efficient and effective health infrastructure, we will save lives and reduce the cost of health care by an estimated \$131 billion annually or 10 percent of America's total health care spending. In a study released by the WHO, the U.S. ranked 37th out of 191 national healthcare systems.

Healthcare in Spain:

If you pay social security, healthcare in Spain is free or low cost. Like many countries, however, the health service in Spain has a waiting lists to consult specialists and for non-urgent operations.

HEALTHCARE IN IRELAND

CORE POLICY OBJECTIVE HEALTHCARE: To provide an adequate healthcare service, focused on enabling people to attain the World Health Organisation's definition of health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

Healthcare is a social right that every citizen should enjoy. Citizens should be assured that care is guaranteed in their times of vulnerability. The standard of care is relative to the resources and expectations of the society. The obligation to provide the right to healthcare rests on all citizens.

In a democratic society, this obligation is transferred through the taxation and insurance systems to governments and other bodies who assume/contract this responsibility.

In November 2001, the Government published a National Healthcare Strategy for the continued development of the Irish health services. This strategy, entitled Quality and Fairness: A Health System for You, was developed after consultation with both consumers and service providers. The strategy has four key principles, namely, equity, people focus, equality and accountability (OECD 2003).

Three of these principles were also the basis of the last national health strategy of 1994, entitled, 'Shaping a Healthier Future'. Yet, inequality increased during this period as waiting lists became longer, and the commitment to the development of the community sector was not fulfilled. Where this strategy differs is that it sees six main frameworks for change, and one of the key factors of this change would be the primary-care sector. To support this, a strategy entitled 'Primary Care: A New Direction' was launched.

The launching of Primary Care: A New Direction as part of the strategy gives a commitment to the development of a model of primary care based on the Alma-Ata definition of primary healthcare, recognising that health is much broader than disease and any one profession. Primary care is seen as the development of good working relationships between all professional team members in the field. However, there was no mention of the community health voluntary worker as having a part to play in the development of these teams. To ensure the development of Primary Care: A New Direction, it is necessary to shift the healthcare budget's emphasis away from a central focus on hospital care towards community care (Hunter and Robinson 2002:301-305).

A balance must be struck between the funding provided for high-tech/acute care and community care. World Health Organisation (WHO) policy, agreed in 1972, set out to shift the emphasis to community care. For the WHO policy to work, there must be a more realistic shift in emphasis to community care, with a corresponding transfer of government resources.

To enable this to occur, it will be necessary to, educate the public about the benefits of having a local health service and encourage them to use it, and support them when they do, place emphasis on preventative healthcare; encourage hospital consultants to work in the community; make special provision for people who are geographically or socially excluded; research, pilot and evaluate alternative initiatives in the delivery of healthcare. (ref.: THE IRISH TIMES...on the web. Thursday, July 10, 2003. Special: CORI JUSTICE COMMISSION SOCIO-ECONOMIC REVIEW 2002. Monday, April 8, 2002. An Agenda For Fairness – Ensuring Economic Development, Social Equity, Sustainability.

Ireland has a population of approximately four million people, a third of whom live along the eastern seaboard close to Dublin, the capital city. About 75% of the healthcare service in Ireland is publicly funded mainly from general taxation and 25% is funded through voluntary health insurance premiums. Public health expenditure makes up approximately 20% of government expenditure. Private health expenditure accounts for almost 25% of health expenditure and approximately 2% of GNP. The Irish healthcare system is a mixture of a universal health service, free at the point of consumption and a fee based private system, where people subscribe to private medical insurance to cover their medical expenses.

People are entitled to free or partially free health care services based on their ability to pay. Approximately 37% of the population has full eligibility for health services. Those

who are eligible receive a medical card which allows them access to the full range of health and hospital services (Health Systems Trust 2003)..

Sixty three % of the population is not eligible for free GP services, dental or aural services but they are entitled to free maintenance and treatment in public hospital wards. Almost half the population in this latter group takes out private medical insurance, thus paying twice for what they are entitled to, free of charge.

The Health Act (1970) set up a regional system of health service provision with the establishment of eight regional Health Boards which are responsible for allocating resources to the services in the region. Until recently, the Department of Health & Children funded separately the thirty four public voluntary hospitals, but these have now come under the control of the Health Boards. In addition to the sixty acute hospitals within the public health sector, there are also eighteen private hospitals in Ireland. It is interesting to note that despite its small size, Ireland is almost top of the league in relation to the provision of free access to health care services. In terms of overall standard of care it is high, and according to an OECD Report in 1997, compares favourably with that provided in much wealthier countries.

The private healthcare sector in Ireland is intended to act mainly as a top-up to the public health care system in Ireland. Such a mixture allows both sectors to play a complementary role in the provision of health care in this country. The co-existence, for example, of public and private practice in publicly funded hospitals helps to ensure that

the same consultant staff is available to both public and private patients. There is a much more limited service available in the private sector. Accident and emergency services, for example, are almost exclusively provided in the public sector, while most admissions to private hospitals are elective.

(ref.: Position paper on Irish Healthcare libraries for SCONUL-ACHS where they might work in co-operation with Irish colleagues.)

IRISH HEALTH CARE SYSTEM FUNDING

In Ireland public funding makes up approximately 78% of all the money spent on health care. Private funding, through insurance arrangements, makes up approximately another 8.5% of funding. The balance is what individuals pay in out-of-pocket expenses; for example the fees of non-medical cardholders pay for GP and other therapy services.

The public money spent on health comes from funds raised primarily through general taxes. The money raised is allocated to the Department of Health And Children and, in turn, to the regional health boards and the Eastern Regional Health Authority. The boards provide many services themselves and use some of the monies to pay other health services providers (such as health agencies, voluntary hospitals or voluntary bodies) who provide health and personal social services in their region. The total amount of money spent on health in 2001 (excluding capital funding) will be in excess of 5.3 billion pounds, more than double the amount spent in 1997. More than half of the

money invested in the last five years has been directed to continuing care services, i.e. services for people with disabilities, older people and children (Eva and Morgan 2004).

Eligibility for services

Any person, regardless of nationality, who is accepted by the health boards as being ordinarily resident in Ireland, is eligible {To be eligible means that a person qualifies to avail of services, either without charge (full eligibility) or subject to prescribed charges (limited eligibility)} for health and personal social services. About one-third of the population holds medical cards which entitle them to receive services free of charge. Non-medical cardholders are entitled to some services free of charge. Effectively, everyone has coverage for public hospital services with some modest charges, and some personal and social services, but only medical card holders have free access to most other services (including general practitioner services) (Eva and Morgan 2004: Brown 2003).

Under the Health Act 1970 eligibility for medical cards is based on a notion of 'hardship'. In today's terms, 'hardship' is defined by income guidelines drawn up by the health board CEOs, which are used as a means test to determine eligibility. These guidelines are revised annually.

Health board CEOs also have discretionary powers to award a medical card on hardship grounds even when a person's income exceeds the guidelines.

A number of other schemes govern eligibility for services for certain groups of the population. These include the Long-Term Illness Scheme; Infectious Diseases Regulations; Maternity and Infant Care Scheme; School Medical Service; Public Dental Service; Nursing Home Subvention Scheme; preventive services (such as primary immunization schemes and child health clinics) and early detection services (such as National Breast Screening Programme).

HEALTH CARE IN INDIGENOUS SOUTH AMERICA

Things are not going well with the healthcare provisions in the Amazon area. It is time to hold a broad discussion on the health situation of the indigenous peoples in the Amazon area and to initiate forms of cooperation. The enormous gaps with regard to basic healthcare are, unfortunately, becoming visible due to the frequent cases of infectious diseases such as malaria, tuberculosis, diarrhoea, multiple parasitism and HIV/aids.

The Novib counterparts engaged in health-care work in the Amazon region want to do more than just look on. They have started what is perhaps the most extensive health programme in the north-western Amazon area: the indigenous healthcare project 'Salud Indígena Amazonica' (Siama). Siama combines the expertise and experiences of the

population of the Amazon area and the border areas of Colombia, Venezuela and Brazil and has set itself the objective of increasing cooperation, developing broadly-supported policies, improving the provision of information in the South and North and attracting more attention and respect for the indigenous cultures. Siama has been designed to be a world-wide network of institutions, people and social organizations. The network is part of a wider strategic alliance which, under the name Canoa (Cooperacion y Alianza et al Norte y Oeste Amazonico), combines the efforts of different indigenous and non-governmental organisations (NGOs) from the Northern and Eastern part of the Amazon area and searches for ways of protecting the rights of the indigenous peoples and of conserving the environment (OECD 2003).

HEALTH CARE IN COLOMBIA

The programme aims to ensure the participation of the indigenous organizations, NGOs and governmental bodies that are active in healthcare work in the Amazon area. These activities are being coordinated by the NGO Fundacion Etnollano from Colombia. This network not only offers a webpage (www.redsiama.org) with practical information on, for example, new developments, epidemiological trends, best practices and news from other parts of the region, but also to establish links with other interested parties via periodical publications and visits to different community health programmes in the region. The umbrella organization of Indigenous Peoples of Colombia (Opiac) ensures regional cohesion in the health models by encouraging the various indigenous

communities to make a diagnosis of their health situation and by providing training courses in the legal frameworks and social security standards. These activities will be executed via workshops, both at provincial and regional levels, consultations with government bodies and the publication and production of videos and newsletters.

HEALTH CARE IN BRAZIL AND VENEZUELA

The association 'Health without Borders' (Saude Sem Limites) and the Federation of indigenous Organisations of Rio Negro (Foirn), both of which operate in Brazil, the Regional Organisation of Indigenous Peoples from the Amazon area (Orpia) and the Centre for Research and Control of Tropical Diseases (Caicet), both operating in Venezuela, contributed to the project in the form of the systematization of information, local experiences, the results from their 'pilot-programmes' and their specific know-how in the field of legislation. Moreover, all the organizations are going to take part in international seminars on an indigenous health policy for the Amazon area. The project also wants to raise the level of participation by the indigenous population. Within this framework, solving the health problems facing the indigenous population means taking an integral look at the problems in the region (JECD 2003).

The paradigms of individualistic healthcare of the national healthcare systems will be replaced by others which have much more respect for the manner of thinking of the indigenous communities. Fora, newsletters, progress reports on projects, publications,

observations and discussions on different aspects of the problems in various situations concerning indigenous healthcare will be the main focus in Red Siama.

The chapter examined various healthcare systems internationally in a comparative perspective . In this way it is hoped that lessons can be drawn for the South African case.

CHAPTER 4

RDP VS GEAR OBJECTIVES IN THE HEALTHCARE CONTEXT

In the early 1990's, unions, civic movements and social organizations began to develop a plan for transformation, for post- apartheid South Africa. The process involved in depth and extensive consultations within the ANC, its allies and wide range of experts. This endeavour resulted in the formulation in 1994 of the RECONSTRUCTION AND DEVELOPMENT PROGRAMME (RDP). The objectives of the RDP were to address the social and economic problems confronting South Africa.

The key aspect of the RDP was that it was linked to reconstruction and to development. It recognized that the lack of socio-economic needs are interrelated e.g. shortage of housing and jobs, inadequate education and health care.

The five key programmes were:

- *meeting basic needs;
- *developing human resources;
- *democratizing the state and society;
- *building the economy; and
- * implementation of the RDP.

"the need to create employment and a better life for all our people is the central objective of the economic policy of this government. The RDP remains the basic policy framework to achieve this objective". (Alec Erwin, Minister of Trade and Industry , May 2001).

As regards healthcare the RDP proposed to give free medical care to children under 6 years and to homeless children; improve maternity care for women; organize programmes to prevent and treat major diseases like Tuberculosis (TB) and AIDS (Acquired Immune Difficiency Syndrome).

The GROWTH EMPLOYMENT AND REDISTRIBUTION (GEAR) is a macroeconomic strategy adopted by the Department of Finance in June 1996. This strategy aims at a five year plan to strengthen economic development, broadening employment, and redistribution of income and socio-economic opportunities in favour of the poor. GEAR is a government driven initiative. Initially the key goals of the policy were economic growth of 6% in the year 2000, inflation, less than 10%, growth in employment, reduction in deficit on the current account and balance of payments; improvement in income distribution, relaxation of exchange controls. GEAR has managed to reduce deficit and inflation, however South Africa's growth rate remains at 3%, far short of the anticipated 6%. The South African government is steadfast about its GEAR policy maintaining that this policy will provide the country with long term economic growth.

COSATU, a union based organization, believes that GEAR is failing to deliver on its projections, and with its focus on monetary and fiscal targets; conflicts with the goals of the RDP, and meeting peoples' socio-economic needs. One of the consequences of GEAR is that government has slashed its spending between 1996 and 1999. As a result services such as healthcare suffering. The government agrees that GEAR'S limits on expenditure limits the ability to meet social development goals of the RDP. According to the South African National Housing Code, the goals of GEAR to implement Housing Programmes are contingent on the availability of funds. Simultaneously, cuts in government spending constrain the government to extend its capacity to expand the scope of subsidies or grants.

Data from 1998/1999 indicate reduction in per capita financing of healthcare by government. This curtails the access and equity for healthcare. President Thabo Mbeki, in his annual state of the nation address, February 2001, alluded to his dichotomy by expressing the view that between 1996 and 1999, more than 400,000 formal sector jobs were lost, impacting on families as no form of social security exists for the unemployed. The jobs that are being created are generally in the informal sector, and these are lowly paid positions. GEAR appears to be in conflict with the RDP, as regards the reduction of poverty and a more equal distribution of wealth. South Africa remains a divided economy

with the vast majority of poor people being black and most of the wealthy being white.

This chapter examined briefly the differences between the RDP and GEAR and their possible repercussions on the financial realities for a national health care service.

CHAPTER 5

RESEARCH METHODOLOGY

INTRODUCTION

This chapter will highlight the methodology used for this study. It will describe the sampling techniques that were used, as well as the instruments used. Manual coding and tabulation methods were used in the analysis process. Questions asked and their responses have been extracted from the questionnaires and interviews with the respondents. Data analysis was viewed from a qualitative and quantitative perspective.

The study area

KwaZulu–Natal was used as the study area, and more specifically, the public health sectors and private health sectors. Apart from people not associated with healthcare, this research project was chosen to test the attitudes and beliefs of healthcare professionals specifically those working in the health care sector. By doing this, this research confined itself to a predetermined section of the population. Much is being discussed about the development and the lack in healthcare, yet very little is being done about it. Health care professionals and other service providers, both in the private and public sectors have to function within the ambit of healthcare legislation. More restrictions are placed on public

healthcare workers as their views remain confined within the framework in which they work. In the private sector, on the other hand, a reasonable amount of flexibility exists. However, with restricting legislation being enforced, this sector will find itself in a similar position to that of the public health sector. Legislation viz. the Health Bill, is preparing the South African healthcare environment for the eventuality of a unified health system.

SAMPLING TECHNIQUES

Judgemental sampling was utilised to select 50 respondents. Interviews were conducted with respondents from different areas of KwaZulu-Natal at state hospitals, private hospitals, general practitioners, nursing personnel both from the public and private health care sectors. Initially 50 interviews were anticipated, however due to time constraints, by respondents and incomplete questionnaires, the total number of questionnaires used for gathering statistical data was 30.

RESEARCH INSTRUMENTS

INTERVIEWS:

Three pilot tests were done to evaluate any possible problems with the questionnaire, time required to answer and other details important for the study.

Very little was problematic, except some questions appeared to be too general. Face to face interviews were conducted at the location of the respondents. After an introduction, the letter from the University of KZN, written by the thesis supervisor was handed to the respondents, to authenticate my credentials. The respondents were asked the questions and their responses were recorded in a totally non-judgemental manner. Only when respondents tended to veer off the topic, were they asked in the interests of time, to offer their considered response.

QUESTIONNAIRES:

Questions were put to interviewees who were asked for their responses: the questionnaires were not handed to potential interviewees. Face to face interviews were conducted. The questions asked of respondents assisted the researcher in understanding more the attitudes and beliefs of health care professionals in the public and private healthcare sector. The responses to questions also gave the researcher an understanding of how much or how little people knew about their constitutional rights, as the respondents are first and foremost citizens of South Africa and then healthcare professionals second. The responses also gave the researcher insight into how much respondents knew about economic and other fundamental statistics of South Africa, and information on their knowledge of other countries. It also tested respondents

creative thought processes regarding solutions to the health care access in South Africa.

LIMITATIONS OF THE STUDY

Due to time constraints, it was not always possible to complete all interviews and as a result, 30 questionnaires were completed out of 50. In some instances prior appointments were made with potential respondents, but had to be cancelled or postponed by them and never followed up. In retrospect questions could have been more specific, and perhaps the number of questions reduced to 10 instead of 20.

In this chapter the research methods utilised by the researcher were outlined. The next step is the analysis of the data.

CHAPTER 6

ANALYSIS OF DATA

This chapter will focus on the analysis of data collected from thirty questionnaires. The interviews were done as a face to face interview, using questionnaires, controlled by the interviewer. Each questionnaire contained twenty questions, with open ended and closed ended questions. The theme of the questionnaire sought to elicit from question one to twenty, respondents attitudes and beliefs, and knowledge about healthcare in South Africa. It was hoped that the sequence of questions followed a pattern so as to elicit from question one to twenty, respondents attitudes and beliefs, and knowledge about healthcare in South Africa.

The responses to the open ended questions were, in some instances, too wide, hence an attempt was made to categorise them into similar concepts. Twenty questions were posed and correspondingly twenty categories were identified for the purpose of this research.

This section will examine the responses to the questionnaire, by examining each question:

QUESTION 1

Are you familiar with what a National healthcare system is all about?

The majority of respondents expressed a yes response, 25 out of 30 which represent 83%. They articulated that they were familiar with what a national health system is all about, indicating that the healthcare profession is aware of current perspectives in healthcare.

The respondents who answered no and who represented 5 or 17 % of the healthcare professionals interviewed, came from a mix of nurses and general practitioners. This indicated that there was a percentage of the respondents who were involved in the healthcare sector but were not keeping abreast with developments in the healthcare sector. Their response was a blank no. One would have thought that being in the healthcare sector, these respondents would be familiar with these concepts.

QUESTION 2

Do you think that healthcare is a basic need in every Society?

Yes: 28 – 93%

No: 2 – 7%

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The respondents were very clear about healthcare in society. Perhaps as a result of their being healthcare professionals, their attitudes about healthcare would be positive. This question was an abstract one in that there was no discussion entered into as to why healthcare should be viewed as a basic need. All that was required from respondents was a yes or no response. However this question might have stimulated some thought processes about society and basic needs. This question might have set a platform for other questions where respondents were required to answer to a greater degree, their answers about societies basic needs.

QUESTION 3

Which countries do you know of have a National Healthcare System? And name them!

25–83% of respondents named other countries: 5-17% - did not know

the responses to this question almost mirrored that of question 1. His question engaged respondents to test their knowledge of global healthcare in comparison with South Africa, particularly National Healthcare Systems. The majority of respondents ranked Britain as the first example with other countries like Spain, Sweden, Italy, Brazil, France, Ireland, as examples. This reflected

that respondents knew about healthcare systems in other parts of the world. This suggested that the understanding of other healthcare by comparison with South Africa, particularly National Health Systems. The majority of respondents ranked Britain as the first example with other countries like Spain, Sweden, Italy, Brazil, France, Ireland as examples. This reflected that respondents knew about Healthcare Systems in other parts of the world. This suggests that the understanding of other health care systems was good. It also reflected that healthcare professionals were not entirely happy with the status of healthcare in South Africa, and that it needed improvements.

Comparisons generally emanate from a sense of lacking in what is being thought about and in this case, healthcare in other countries. This question could also reflect that the perceptions of healthcare in South Africa, by other healthcare workers is that it needs transformation to come bring itself up to world standards(Brown 2003)

QUESTION 4

Do you think that South Africans have a right to access Healthcare?

Yes: 29–97%

No: 21-3%

This question aimed to test the knowledge of respondents about their Constitutional rights. Only 1 respondent did not believe healthcare is a right. The majority 29 respondents 97% believed overwhelmingly that it is the right of every South African to access to comprehensive healthcare. This reflects that healthcare professionals are in tune with the country's democracy and as democracies evolve and empower people to challenge their constitution, socio-economic rights are in need of being challenged and delivered by the state.

Healthcare professionals as can be seen from their responses to this question, are now questioning the healthcare status quo, and by reflecting their positive responses show that they are ready for positive changes to healthcare in South Africa.

Question 5

Does the Constitution of South Africa and the Bill of Rights grant this right to every South African?

Yes - 28 - 93%

No – 2 – 7%

Following from question 4, this question also reflected that health care workers knew the constitution. This was a positive response in that it projected where citizens, more especially health care workers, are at fault with their constitutional

rights. In the context of this research, it makes interaction and discussion meaningful because knowledge about the subject matter is presupposed. It also means that as services providers, health care professionals are aware of their obligations to the patient and the constitutional right to grant access to health care to all.

Perhaps the public and private health care sectors are constantly educating and updating their professionals about their obligations to the patient in line with legislative framework of healthcare in South Africa.

Question 6

Approximately what percentage of the Gross Domestic Product does South Africa apportion to Health care?

20 (66%) of the respondents did not know the answer, 10 (34%) knew the answer which is 9% of the GDP. This suggests that the respondents were not statistically aware of percentages, but were aware of the overall situation of healthcare provisioning in South Africa. However it was hoped that respondents were aware of the percentage contribution towards health care as this would enable them project whether South Africa has the capacity to establish a National health care system.

Having this knowledge would enable the respondents to make comparisons with other countries' health care systems, although this would be relative, but would provide justification for a National health care system to be established in South Africa.

QUESTION 7

What is the approximate population of South Africa?

Arising from this question 20 (67%) of the respondents answered 42 million which is the correct answer and 10(33%) either 30 million or 47 million.

This was encouraging because as was seen in question 6, respondents had a broad knowledge of South Africa's dynamics, even though they might not be statistically correct. This knowledge would enable the respondents to ascertain whether a country could afford to establish a national health care system, taking into account the population and funding from the state.

Questions 6&7 offer insight into the respondents will offer further suggestions on how to finance a national health care system. It was hoped that if the respondents knew about other countries and their health care systems and possibly their dynamics, they would be able to contextualize health care in South Africa in relation to its own dynamics.

QUESTION 8

Do you think that a healthy society is a healthy one and why?

It is assumed that healthcare professionals' principal concern is the healthcare of their patients and by extension, the society at large. If one views this in context, healthcare professionals would want every citizen to have access to healthcare in South Africa. 27 (90%) of the respondents agreed that a healthy society is a productive one and that it increases productivity as a whole, and benefits everyone. In order to sustain a healthy society, access to healthcare, needs to be available at all times. Therefore sustaining productivity in society hinges on a healthy society. The majority of respondents agreed that good health is necessary to promote productivity. It might be viewed that the respondents were thinking about increasing growth rate for South Africa, and following from this, a National Health System could be realised as the gross domestic product (GDP) correspondingly increases, as well as a larger percentage can be allocated to healthcare. This might suggest that healthcare and access to it is vital at this stage, especially to establish a National Health System available to all South Africans in order to promote enhanced productivity.

QUESTION 9

If South Africa were to introduce a National Health System what impact would this have on the private medical sector?

27(90%) of the respondents believed that the introduction of a national health system in South Africa would have a major impact, 3(10%) believed that there

would not be much impact or none at all. As the respondents were interviewed from both the private and public sector, it was evident that there was some commonality in view about the impact that a National Health System will have on the private medical sector. Respondents from the private health sector would also have been bias towards the major impact on the creation of a National Health System, would have on the private medical sector. Whichever way one views their responses, it was clear that healthcare makes from both the public sector and the private sector agree that there would be a major impact on the private medical sector.

QUESTION 10

Do you think that establishing a National health care system in South Africa will be an expensive exercise?

16 (53%) answered yes and 14 (47%) answered no.

Bearing in mind that in question 6, sixty six percent of the respondents could not approximate the percentage of Gross Domestic Product allocated to health care in South Africa, question 10, posed a problem for respondents. This indicated that they had insufficient knowledge to answer this question adequately.

At this stage of the questionnaire it was becoming apparent that there were variances in responses between the private and public health care professionals. Different perspectives were emerging.

The private sector believing that their sector is involved in the ability of patients to pay for services and the public health care sector believing that health care should be accessible to all.

The private sector could be viewing themselves as having the financial and managerial inputs and as such view the establishing of a national health care system as expensive.

On the other hand the public sector health care professionals might have been in the majority who suggested that it would not be an expensive exercise on the basis that the State has a constitutional obligation to provide access to health care to all its citizens, irrespective of how much it costs.

QUESTION 11

Do you have any suggestions on how to finance a National Health care System?

Some examples were provided such as; increase in taxes, surcharges, there was an opportunity for respondents to offer further suggestions.

The majority of respondents suggested that taxes should be increased, they numbered 16(53%); 4(13%) responded that surcharges should be introduced.

5(16%) suggested that that additional finances be obtained from the Lottery Fund. A further 5(16%) believed that a wealth tax be introduced. All these additional revenue should be channelled towards establishing a national health care system.

The responses to this question contradict question 10, because respondents believed that it would be an expensive exercise to establish a national health care system. Perhaps the respondents anticipated question 11, and answered accordingly. However the responses to this question would negate the view that the state be obliged to provide access to health care for all without engaging its citizens to contribute as well.

QUESTION 12

By comparison with other countries, do you think that health care in South Africa is affordable?

26 respondents (87%) answered that it is affordable. 4(13%) answered that it was not affordable. To be able to answer in the affirmative that healthcare is affordable in South Africa pre- supposes that respondents are aware of the cost of healthcare in other countries.

The perplexing view is to what extent are respondents viewing healthcare in South Africa. Are respondents viewing the private health sector or the public

health sector or the health sector as a whole. South Africa is viewed by the global society as a middle income country, but this takes into account only the first world or developed part of our society which measures approximately 7 million out of 42 million citizens. The question arises, is health care affordable to the majority of people in South Africa? Private sector and public sector healthcare professionals suggested that health care is affordable in South Africa. It is possible, the majority of respondents who answered that healthcare is affordable in South Africa are from the private sector.

QUESTION 13

Does South Africa have an established healthcare infrastructure?

14(47%) of the respondents agree that South Africa has an established infrastructure, 16(53%) believe that South Africa does not. The difference in attitudes between the private sector health workers and public sector was apparent in that respondents in the private sector viewed their sector as having a well established healthcare infrastructure.

Respondents from the public health care sector it was obvious viewed the healthcare sector as lacking in infrastructure, particularly in the rural areas. This divergent view from both these sectors reflects the division in the provisioning of healthcare services to South Africa and suggests that this gap needs to be narrowed in the interests of all concerned.

QUESTION 14

If and when a National Healthcare System is introduced in South Africa, do you think it would address issues facing the HIV pandemic?

20 respondents (67%) agreed that the introduction of a national health system for South Africa would address the HIV pandemic. 10(33%) believed that it would not. Arising put of the responses, it cam be deduced that a national health system would benefit the society, and make healthcare more accessible to the growing number of ill people afflicted by this pandemic. Obviously by addressing this issue, South African society would be addressing productivity and ensuring that one has a healthy society. The remaining 33% of respondents did not view access to health care for HIV patients as being of any significance as it would not adequately address the HIV pandemic in a meaningful way and perhaps other priorities in society need be addressed viz. education.

QUESTION 15

Our South African democracy is facing many challenges, one of them is finances. Do you think that the private sector and government should form a partnership to help establish a national health care system, what suggestions do you have?

28(93%) of the respondents believe that the private and public health care sectors should forge a partnership and share technology and other areas of expertise. The private health sector was viewed as having most of the sophisticated technology and better managerial expertise.

The public health sector was viewed as historically having the academic expertise and historical experience.

Between these two sectors a strategy could be planned to spearhead the formation of a national health care system. Respondents from the public sector admit that the private sector has much to offer to enhance health care and make it accessible to all. A unification of both these sectors will benefit society at large.

The remaining 2(7%) were of the opinion if and when the private and public health sectors merge, this will be the beginning of socialism in South Africa and attempts at establishing a national health care system is a socialist manoeuvre.

Question 16

Are there more important priorities facing South Africa than health care?

14(47%) believe that other priorities exist like crime, unemployment, education, transport and the slow economic growth. Health care for these respondents was viewed as being of a lesser priority. These responses came from the

private health sector who obviously see health care as a financial endeavour and for those that can afford it.

However 16(53%) of the respondents believed that health care is the most important priority facing South Africa. This response came mainly from public health care professionals ,Their expressions suggests that because the public sector does not place the ability to pay as all important, their objective is based on providing a service to the people as designed by government.

QUESTION 17

Should the government divert revenues from other budgets to healthcare?

Eighteen respondents (60%) believe that this should be the case, more especially the defence budget should be reduced and diverted to healthcare. They believe that since South Africa is not actively engaged in war, it does not make sense to maintain or increase the defence budget. Some of the respondents exposed their views about the lack of infrastructure in the rural areas, skills and salaries to boost the public healthcare service. This question generated most of the views from the public healthcare professionals. This is not to suggest that views were not forthcoming from the private health sector.

Respondents in this sector also expressed views that institutions were acquiring huge profits at the expense of their expertise. Diverting revenue from

other budgets to healthcare would improve the lot of health care professionals, create more stability in the workplace, health workers would feel motivated and would be willing to share their expertise to other areas that are in need.

12(40%) respondents were not in favour of the government diverting revenue from other budgets to healthcare. They believe that finance must be sourced from other avenues like increasing taxes, imposing surcharges and drawing monies from the lottery fund. Although this question required a blanket no answer, respondents took the opportunity to express their views in spite of being steered away to the answer. The above responses are over and above the required answers to question 17 and offer one an insight into the rationale behind the responses.

QUESTION 18

Where would you rate health care in priority?

1 being the least important and 10 being most important

In this question a ranking scale from 1 to 10 was offered as possible ratings.

(See Appendix 2)

16 respondents (53%), rated healthcare from 6 to 10 on the rating scale indicating that they rated health care as being very important. This corresponds with the findings in question 16 where 53% of the respondents felt that healthcare was more important than other priorities facing South Africa. 6 respondents (20%) rated healthcare as average in importance indicating that

other socio economic areas were either less important or more important. 8 respondents (27%) viewed health care as least important, indicating that there were more important socio economic issues than health. This ties in with question 16 where 47% of the respondents believed that they were other priorities facing South Africa than health for example crime, unemployment, education, transport and economic growth.

QUESTION 19

What role would private medical aid play if and when a national health care system is introduced in South Africa?

22 (73%) of the respondents were of the view that only the wealthy in South Africa would be able to afford medical aid in the form of top up, cover over and above being covered by a national health care system.

5 (17%) of the respondents did not believe that there would be any role for medical aid schemes once a national health system is established. This might indicate that these respondents believed that medical aid schemes would become non-existent. However in countries with mixed economies, there are forms of alternative medical cover, which people can purchase from insurers or private medical schemes, and also enjoy the benefits of the national health system.

3 (10%) of the respondents were of the view that role of medical aid schemes would diminish. This appears to be a more realistic view in that it echoes what 73% of the respondents believed that top up cover would be available to only those who are able to afford it. Affordability of private health care cover in South Africa even by those who are gainfully employed and enjoy medical aid cover are finding it difficult to keep up with the escalating premiums and are choosing to cancel their cover.

QUESTION 20

Do you think that South Africans Need A National Health System

The majority of respondents 28 (93%) agreed that South Africa needs a National Health care System. Only 2 (7%) believed that the country does not need one.

If one views all the questions in context, it can be seen that the respondents make repeated justification for the establishment of a national health care system.

Even though respondents viewed health care as less important in priority to other socio-economic issues they ultimately agree that there is a need.

The Soobramony case brought into sharp focus the differences between the public health sector and the private health sector, advancing lack of resources as the primary reason for the constitutional court denying him the right to access renal dialysis in the public sector.

The Health Bill advances the cause of a National health System for South Africa emphasizing the provisioning of Primary Health and the devolution of provision from central government to local and municipal authorities.

The reduction in government spending on healthcare is cause for concern. As mentioned earlier, the RDP and GEAR policies appear to be incongruencies and are impacting on the health status of the people who most need access to healthcare. The lack of funding is relative. South Africa is described as a middle income country, by what criteria, whether this description is focused on the wealthy white population, one is not sure, but one is sure that 80% of our population does not fit into this category and does not fit the description of a middle income category. Where do these people find respite in terms of realizing their socio-economic rights e.g. health care.

The findings from the questionnaire show that the healthcare workers also believe that NHS should be established in South Africa. It is shown that healthcare workers have the knowledge of the dichotomies that exist in the wide gap between the public sector and the private healthcare sector.

Apparent from the findings is that there is a common thread of understanding that there is a wide gap in the provisioning of healthcare services between the private and public health services. To bridge this gap from the responses it was shown that there should be a forging and pool of resources and expertise to bring the two sectors together to form a unified health service for the benefit of all.

The majority of respondents was familiar with the healthcare system and echoed that it is a basic need in every society. Respondents also knew the concept of a National Health System that exists in other countries. Respondents also knew their constitutional rights and the corresponding states obligations.

The knowledge by respondents on statistical information was below average, but performed well on the open ended questions, where answers were required to offer personal views and beliefs. There was an overwhelming response that healthcare in South Africa is unaffordable and that the government should do more to improve the infrastructure.

Respondents felt that private and public healthcare providers should co-operate and share the expertise for the benefit of all. More respondents were of the view that healthcare is a top priority over and above all other socio-economic issues as good health is a precursor to all else. Respondents also felt that

private medical care or medical aid will always be present as a top up or additional healthcare cover for those that are able to afford it. However, medical top up cover will become prohibitively expensive and will only be affordable to those who can afford to purchase it. It will be out of reach for the average South African. Having said that, when a National Health System becomes a reality, it will ensure access to healthcare for the majority of the people.

Funding of a National Healthcare System was a wide topic to focus on for respondents as there are many other suggestions viz. contributions from the lottery; gambling; wealth tax deductions from payroll; deductions from corporate taxes; land tax; additional surcharges from alcohol, tobacco and other luxury items.

The general feeling is that South Africa contributes a large portion of its GDP towards healthcare, relative to other countries. Yet, our provisioning of healthcare is constrained. South Africa and the United States are the only two countries in the world who do not offer free health services to its citizens.

South Africa is unique in its demographics, each country can assert the same, and would be correct in saying so. This research shows that the beliefs and attitudes of healthcare workers support the establishment of a NHS in South Africa given all the constraints. The manner in which the questions were

formulated gave respondents a perspective of the socio-economic and political history of South Africa and hopefully made them aware of their existence within other constitutional states of South Africa. When one considers that over 80% of the population of South Africa relies on public health, there is an overwhelming swing towards the establishment of a unified health system for all South Africans.

The present divide furthers the gap between the haves and the have nots and does not augur well for a stable South Africa and its democracy. Health is a topical issue in South Africa and underpinning South Africa's productivity is a healthy society as over 600 people are dying each day from AIDS and related diseases.

When people are not healthy it affects their ability to be productive. Due to the inequalities, repression and unjust system of Apartheid, the vast majority of South Africans were allowed to face ill health, preventing them from gainful employment, not that there were any jobs to be had. The spiral of afflictions on the repressed population of South Africa has been enormous and it is apparent from the research that the vast majority of respondents agree that healthcare is vital and a priority which government needs to attend to urgently.

A swift approach will be the National Health System, which will give people the good health to become proactive. There are enterprises in South Africa, which

are being allowed to prosper viz. the lottery and gambling. These prosper and benefit alongside a society that is struggling. They may be allowed to continue but must be forced to contribute a part of their takings towards noteworthy causes, such as healthcare.

According to Appendix 1, the majority of respondents agree that the private healthcare sector combines its resources with that of the public sector to establish a National Healthcare System. As was anticipated, one respondent's view was that this concept would be a socialist manoeuvre and discredited it. The private sector healthcare infrastructure is amongst the finest in the world, it would be in the interest of the nation if this infrastructure was shared with the entire nation.

South Africa's transformation needs shared expertise across all the fundamentals of our society, if it is going to arrive at a stable democracy. It is also comforting to see that only 6% of respondents were against transformation of healthcare. These respondents viewed the unification of the private and public healthcare services as a socialist manoeuvre.

CHAPTER 7

CONCLUSION

INTRODUCTION:

This chapter described the study area, sampling technique; research instruments and questionnaires. The reasons for undertaking this research were also highlighted as well as the limitations of this research. However the analysis of the questionnaires will provide a better understanding of the topic and will also assist in offering some solutions and recommendations for health care in South Africa.

This research attempted to obtain the attitudes and beliefs of health care workers in KwaZulu-Natal to the establishment of a National Health System in South Africa. This study focused on health care workers in both the public and private health care sectors.

EVALUATION

According to the findings, there was an overwhelming YES to the establishment of a National Health System in South Africa. There was an average to below average response to knowledge of the demographics of South Africa. As these questions were statistically based, it could be understood that it could have been a question of remembering exact figures. The reasoning behind these questions was to elicit some rationale from the respondents for arriving at a decision that a National Health System is viable for South Africa.

The responses to questions on private medical aid cover offered this research study insight into how respondents perceive the status of health care, the economy of the country, the options available to those people who are unable to afford private health care and the status of the public health sector.

Respondents were generally aware of the concept of a National Health System, evidenced by naming countries abroad where it exists.

Other social priorities like housing, employment, transport, and education featured side by side with health. However, health care was viewed by respondents as a top priority. It is quite possible that due to the exclusive sample of health care workers, it was not a surprise response.

However, it is also possible that being in the health profession, the respondents were expressing their criticism of the status of health care in South Africa by rating health care as top priority.

There was clear evidence from the findings that health care workers are in favour of a partnership or cooperation between the private and public health care sectors, citing a mutually beneficial co-existence in which each sector maintains its integrity but is unified in a common objective to offer access to health care services to all South Africans.

Good health was seen a main ingredient for improved productivity, a sense of well being and contributing to the national good. Respondents were clear in their views about this aspect and also maintained that in order to establish a National Health System to provide access to the greatest number of people, funding would have to be sourced from additional income taxation, levies, taxes and surcharges on alcohol and tobacco and a significant contribution from the Lottery Fund. Respondents tended to agree that financing a National Health System would be an expensive exercise and that monies should be extracted from the above sources.

There were differences in opinion amongst respondents as to whether South Africa has the infrastructure to roll out a National Health system. 50% believed that South Africa has the infrastructure, mainly concentrated in urban areas, while lacking in the rural areas. The other 50% believed that much more needs to be done to improve and increase the infrastructure, both in the urban and rural areas, but particularly in the rural areas.

Respondents also suggested that other budgets, namely defence, ought to should divert some of their revenue to health which, in South Africa, is a greater priority.

Overall, it was clear to see that health care workers in KwaZulu-Natal are in favour of the establishment of National Health System for South Africa. They see it as viable.

RECOMMENDATIONS:

A society that suffers so much ill health is bound to suffer poor productivity. Based on the iniquities and unjust system of apartheid, which left a legacy of repressed and impoverished people, the inheritance of which our new government bears the burden, there is a need to strengthen the resolve of our nation and it is incumbent on government to do just this.

A comprehensive health care system needs to be established to protect the vast majority of our people and to make access to health care services a reality. A National Health System based on the British model is proposed; developments to take place speedily by enacting legislation to curtail the burgeoning private sector which only benefits 7 million people of a total of 42 million people in South Africa.

As is seen from the history of NHS in Britain, almost every year since 1948, some piece of legislation is passed to bring the public and private sectors closer, with a view to unifying health care in Britain.

Every country has its own peculiar circumstances. Common to most countries with a NHS appears to be the long waiting queues. However, notwithstanding this fact, the state is fulfilling its obligation!

The South African Constitution guarantees access to health care providing that resources are available. Establishing a NHS in South Africa by taking cognisance of possible sources of additional revenue will go a long way towards the state fulfilling its obligation to the Constitution and therefore the people of South Africa.

The forging of closer cooperation and skills and expertise between the private and public sectors will also smooth the transition towards the NHS.

It is imperative if NHS is to be established and succeed, that legislation be regularly passed to engineer the process and form solid linkages between the private and public health sectors. The introduction of legislation will bring about equity to an already very skewed healthcare situation in South Africa; where R30 Billion is spent on 35 million people for healthcare whilst R40 billion is spent on 7 million people for healthcare.

Clearly not only will statisticians find this skewed but it is blatantly clear to all that if people have money, they can maintain their basic healthcare needs while those who are disposed are not in a position to do so.

The constitution of South Africa needs to reflect the transformation needs of the greater number of its citizens, and socio-economic rights need to be protected and enhanced – and addressed by the constitutional obligations of the state.

Challenges against the constitution of South Africa for addressing basic socio-economic rights should not be an issue. These rights are enshrined and guaranteed in the Constitution, the highest law in the land.

South Africa is viewed as a middle income country, contributing approximately 9% of its GDP towards health, although this represents a huge contribution by comparison with other countries. Perhaps this is where skills and expertise from the private sector can help in the transformation and implementation of the health system. It can offer management skills, financial skills, medical expertise and planning skills. Like with all other areas of transformation in South Africa, healthcare is not excluded from being revamped for the hood of the entire nation.

The Health Bill offers hope in that it envisions a National Health System based in the principles of Primary healthcare. The rolling out process of this Bill will be long and tedious given all the established fundamental structures in a very fragmented society.

These structures need to be dislodged and redefined. In other words, South Africa is undergoing a structural change, even government institutions need to be democratised in keeping with the constitution.

Legislation becomes all important in the transition phase wherein all that needs to be done for a smoother change, is enforced by law for the good of all.

The Traditional Healers Act is another area by which the NHS can derive major benefit in that, it could complement the allopathic needs of society and offer cost effective to millions of people and therefore make NHS more viable for South Africa.

Government needs to look at funding of healthcare and the mechanisms by which it seeks to distribute healthcare to priority services in poor areas. Some of the transformation in public health care by government will be lost if government does not prioritise an equitable redistribution of healthcare services to every province.

Government needs to accelerate collaboration between the private and public health care sector. Stakeholders in the private sector need to pursue a cost effective medical service by engaging with service providers, to reduce the cost of medical services.

Employers also have a role to play in negotiating a decrease in cost in private healthcare. With government pursuing the Social Insurance Medical Scheme

for civil servants, it needs to also engage service providers to reduce costs and make services affordable to members.

In some areas of the private healthcare sector, the establishment of private hospitals is going ahead unnoticed, this needs to be regulated by government and legislation passed if necessary to curb expansion and duplication of services. Public hospitals must also be seen to be as a viable option for private healthcare members.

According to the Health Systems Trust, where private-public partnerships are forged, government needs to ensure that these are evaluated within the context of an overarching policy on the private sector. The policy should express the advantages and disadvantages of such a relationship as well as the principles such as equity and sustainability. Lastly COSATU is critical about government's attempts to establish a social health insurance scheme for lowly paid civil servants; they propose a healthcare system for all South Africans irrespective of their status. This view will address the fundamentals of the RDP concerning socio-economic rights such as access to healthcare as enshrined in the constitution of South Africa.

CRITIQUE

This research examined the attitudes and beliefs of healthcare workers in Kwa-Zulu Natal and canvassed their views on the viability of a National Healthcare System for South Africa.

Credit was given to the government for improving the health services, however, there are still inconsistencies in the redelivery of these services to the people of South Africa.

The health Bill promises a National Health System for all, with Primary healthcare at its core. However, the delivery will take time as South Africa is undergoing structural changes.

If challenges against the government are to be prevented, more has to be done to align socio-economic rights with the obligations of the state.

Accessing on socio-economic rights in a fledging democracy such as ours, with inequities still existing, is going to pose many challenges for government. Legislation is needed on every level to constrain the private healthcare sector, to reverse its expansionism and restore a balance between the private and public health sectors. The true value of South African society will then be able to be measured and will not be described as a middle income country. The demographics speak for themselves.

A deliberate interchange between the private and public health sectors needs to take place, to formulate strategies to move speedily towards establishing a National healthcare system.

“A National Healthcare System is long overdue and South Africans have a right to access it, and government is constitutionally obliged to provide it.”

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SURVEY QUESTIONNAIRE

1. Are you familiar with what a National Healthcare System is all about?

yes	no
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2. Do you think that healthcare is a basic need in every society?

yes	no
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3. Which country/ies that you know of, has a National Health System?

yes	no
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4. Do you think that South Africans have a right to access healthcare?

yes	no
-----	----

5. Does the constitution of South Africa and the Bill Of Rights grant this right to every citizen?

yes	no
-----	----

6. Approximately, what % of the its Gross Domestic Product does South Africa apportion to healthcare?

5%	9%	10%
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7. What is the approximate population of South Africa?

30 million	42 million	47 million
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8. Do you think that a healthy society is a productive one and why?

9. If South Africa were to introduce a National Healthcare System, what impact would this have on the private medical sector?

10. Do you think that establishing a National Healthcare System in South Africa will be an expensive exercise?

yes	no
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11. Do you have any suggestions on how to finance a National Healthcare System, eg:

Increase taxes

surcharges

Others-elaborate

12. By comparison with other countries, do you think that healthcare in South Africa is affordable?

yes	no
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13. Does South Africa have an established healthcare infrastructure?

yes	no
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14. If and when a National Healthcare System is introduced in South Africa do you think, it would address issues facing the HIV pandemic?

yes	no
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15. Our South African democracy is facing many challenges, one of them is finances. Do you think that private enterprise and government should form a partnership to help establish a National Healthcare System, what suggestions do you have?

16. Are there more important priorities facing South Africa than health? Please elaborate.

17. Should the government divert revenues from other budgets to healthcare?

yes	no
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18. Where would you rate healthcare in priority? 1-being least important 10 being the most important.

1	2	3	4	5	6	7	8	9	10
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19. What role would private medical aid play if and when a National Healthcare system is introduced in South Africa?

20: Do you think South Africa needs a National Healthcare system?

yes

no

20: Do you think South Africa needs a National Healthcare system?

yes no

SURVEY QUESTIONNAIRE

1. Are you familiar with what a National Healthcare System is all about?

☐ yes ☐ no

2. Do you think that healthcare is a basic need in every society?

☐ yes ☐ no

3. Which country/ies that you know of, has a National Health System?

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19. What role would private medical aid play if and when a National Healthcare system is introduced in South Africa?